

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13584

CERTIFICATE OF DEATH

Reg. Dist. No.

13581 260

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORIOLE				c. LENGTH OF STAY IN 1b LIFE TIME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS ORIOLE x2 7			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GRANVILLE Middle Last BENSON				4. DATE OF DEATH Month 12 Day 31 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELLING FISH				10b. KIND OF BUSINESS OR INDUSTRY HOLSTER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A.							
13. FATHER'S NAME EDWARD BENSON				14. MOTHER'S MAIDEN NAME HENNETTA TERPIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MARY BENSON. PRINCESS ANNE, MARYLAND Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism of brain artery 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & arteriosclerosis DUE TO (c) Senility INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 10 yrs. 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 31, 1957 , to Dec. 31, 1957 , that I last saw the deceased alive on Dec. 31, 1957 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. Lewis M.D.				ADDRESS (Street, city or town, state) Princess Anne, Md. DATE SIGNED 1/2/58			
PHYSICIAN'S NAME (Type) A. C. Lewis, M.D.				Princess Anne, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/5/58		22c. NAME OF CEMETERY OR CREMATORY ST JAMES		22d. LOCATION (City, town, or county) (State) ORIOLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Johnson ADDRESS				24a. REC'D BY REGISTRAR 1958 DATE		24b. REGISTRAR'S SIGNATURE Dr. H. Johnson	

CERTIFICATE OF DEATH

BUREAU V. 2

DEC 10 1957

RECEIVED

13583

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gandy Lane				d. STREET ADDRESS Gandy Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle EVANS, Sr. Last EVANS, Sr.				4. DATE OF DEATH Month Dec. Day 28 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Crabs & Oysters		11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Mouldin Evans				14. MOTHER'S MAIDEN NAME Elizabeth Horner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-3537		17. INFORMANT Address James Evans, Jr.—Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hemoplegia, rt. side Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Dec 24, 1957 , to Dec 28, 1957 , that I last saw the deceased alive on Dec 28, 1957 , and that death occurred at 11:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED C. G. Rawley ACTUAL SIGNATURE C. G. Rawley M.D. PHYSICIAN'S NAME (Type) Dr. C. G. Rawley, M. D. Main St.—Crisfield, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 12/31/57	24b. REGISTRAR'S SIGNATURE Barthol S. Adams		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

Dec. 28

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Dec. 28

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 3224 1-23-58 et

13585

13586

CERTIFICATE OF DEATH

Reg. Dist. No.

260

1. PLACE OF DEATH o. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LAURA V. FOOKS				4. DATE OF DEATH Month Day Year 12 22 19 57			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 85 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME WILLIAM P. MADDOX				14. MOTHER'S MAIDEN NAME PRICIA FOUNTAIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address WESLEY FOORS PRINCESS ANNE, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 15, 1955 to Dec 22, 1957 , that I last saw the deceased alive on Dec 21, 1957 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Eldon G. Markman M.D. Princess Anne, Md. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/27/57		22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR PRINCESS ANNE, MD.				24a. REC'D BY REGISTRAR DATE 12/27/57		24b. REGISTRAR'S SIGNATURE R. J. [Signature]	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13587

3587

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle P. Last Hood				4. DATE OF DEATH Month Dec. Day 24 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1890	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real estate broker				10b. KIND OF BUSINESS OR INDUSTRY real estate		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry K. Preston				14. MOTHER'S MAIDEN NAME Anne Rhette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mr. Henry P. Mitchell, Kinston, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burned - Body over half destroyed when house was destroyed by fire DUE TO (b) destroyed when house was destroyed by fire DUE TO (c) destroyed by fire PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Home burned. INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fire destroyed home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1130 12-24 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Manokin Somerset Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.H. Johnson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.H. Johnson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-27, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin Wilson				ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE 12/27/57	
						24b. REGISTRAR'S SIGNATURE R.H. Johnson, M.D. (gr)	

Burned - Body over half
charred when here was
charred if fire

Home found
Fire charred home

130 12-27 ✓ Home ✓ Monmouth, N.J.

R. H. Johnson
Riffler

BUREAU V. 3

✓ December 27 1937

RECEIVED

John Wilson

13588 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

13588

Reg. Dist. No. 2600

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMES QUARTER				c. LENGTH OF STAY IN 1b LIFE TIME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAMES QUARTER X2			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ARTHUR Middle WILLIE Last JONES				4. DATE OF DEATH Month 12 Day 10 Year 19 57			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF				10b. KIND OF BUSINESS OR INDUSTRY CARPENTER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE W. JONES				14. MOTHER'S MAIDEN NAME MARY ROBERTS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address ETHA JONES, DAMES QUARTER, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH months years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 12-5-57 , 19____, to 12-10-57 , 19____, that I last saw the deceased alive on 12-10-57 , 19____, and that death occurred at 10:30 PM M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Everett C. Sutter M.D.							
PHYSICIAN'S NAME (Type) Everett C. Sutter MD				Dames Quarter, Maryland 12-12-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY MACODINA		22d. LOCATION (City, town, or county) (State) DAMES QUARTER, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr. Funeral Home				ADDRESS		24a. REC'D BY REGISTRAR DATE 12/13/57	
				24b. REGISTRAR'S SIGNATURE R. S. Johnson, M.D.			

CERTIFICATE OF DEATH

Reg. Dist. No. 265

13589

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cristfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station xo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCreedy Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rosie E. Logan</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bloxom, Accowac Co. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Littleton Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-14-278</u>	
17. INFORMANT <u>Beulah Price</u>		Address <u>Marion Station, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Condition -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes + C. Int. Nephritis +</u> DUE TO <u>Chronic Myocarditis</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 8, 1955</u> to <u>Dec. 8, 1957</u> , that I last saw the deceased alive on <u>Dec. 8, 1957</u> , and that death occurred at <u>7:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn M.D.</u>		ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u> DATE SIGNED <u>12-11-57</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn, M.D.</u>		<u>Marion Station, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waters Family</u>	22d. LOCATION (City, town, or county) (State) <u>Marion Sta, Som. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>12/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	

MEDICAL CERTIFICATION

516-14-518

BUREAU V.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13590

CERTIFICATE OF DEATH

13591

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 39			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McGready Hospital				d. STREET ADDRESS 323 Locust St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last MYERS, Sr.				4. DATE OF DEATH Month December Day 23, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Myers				14. MOTHER'S MAIDEN NAME Emma Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 213-22-5096		17. INFORMANT Address Mrs. Ella M. Myers, 323 Locust St., Crisfield			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerosis 422.2 DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary & Cerebral						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 5, 1957 , to Dec 23, 1957 , that I last saw the deceased alive on Dec 22, 1957 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Marion Station, Md. DATE SIGNED George C. Coulbourn							
ACTUAL SIGNATURE George C. Coulbourn M.D.							
PHYSICIAN'S NAME (Type) George C. Coulbourn, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/25/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 12/31/57		24b. REGISTRAR'S SIGNATURE Barbara S. Adams	

CERTIFICATE OF DEATH

MARKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		John Jones	
Sex		Male	
Race		White	
Date of Birth		July 15, 1875	
Place of Birth		Philadelphia, Penn.	
Usual Residence		323 Locust St., Baltimore, Md.	
Cause of Death		Laborer-Carpenter	
Place of Death		Baltimore, Md.	
Date of Death		December 23, 1938	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. S.

JAN 8 1939

RECEIVED

George C. Colquhoun, M.D.
 St. Paul's Cemetery
 12/25/38

Wendell & Sons, Crisfield, Md.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13592

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>McCreedy Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RALPH</u> First <u>NELSON</u> Last		4. DATE OF DEATH <u>DEC-22-</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar-2-1881</u>
9. AGE (In years lost birth day) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LORENZO NELSON</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT LAWSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-05-5720</u>	
17. INFORMANT <u>MRS Harriett Nelson - wife -</u>		Address <u>Crisfield Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Renal Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec-19, 1957</u> to <u>Dec-22, 1957</u> , that I last saw the deceased alive on <u>Dec-22, 1957</u> , and that death occurred at <u>4:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.		ADDRESS (Street, city or town, state) <u>33 W. Main St - Crisfield Md</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>		DATE SIGNED <u>12/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury M.E.</u>	22d. LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. E. E. Crisfield Md.</u>		24. REC'D BY REGISTRAR <u>12/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>Bartua S. Brown</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		JAN 15 1893		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		COUNTY	
LABORER		8		M		C		HEART DISEASE		SUICIDE		BALTIMORE		BALTIMORE		MD	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		SECOND		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
JAN 18 1958		10:30 AM		10		30		00		98.6		72		18		120/80	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

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JAN 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

135930

13593

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE				c. LENGTH OF STAY IN 1b LIFE TIME			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE x2			
				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE First Middle NISKEY Last				4. DATE OF DEATH Month 12 Day 25 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/1898	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) MARYLAND	
						12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ELLA PEARL DOANE PRINCESS ANNE, MD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address ELLA PEARL DOANE PRINCESS ANNE, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 20, 1957 , to Dec 25, 1957 , that I last saw the deceased alive on Dec 23, 1957 , and that death occurred at 3:34 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eldon G. Marksman M.D.				ADDRESS (Street, city or town, state) Princess Anne, Md			
PHYSICIAN'S NAME (Type) Eldon G. Marksman				DATE SIGNED Dec 30 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/29/57		22c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR PRINCESS ANNE, MARYLAND				24a. REC'D BY REGISTRAR DEC 30 1957		24b. REGISTRAR'S SIGNATURE R. R. Johnson	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
SEX		RACE		EDUCATION	
MARRIAGE		OCCUPATION		RESIDENCE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

DEC 30 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 6224 1-27-58 et

13594

13593

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>R. 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. 24</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Angie</u> Middle <u>L.</u> Last <u>Sterling</u>		4. DATE OF DEATH Year <u>1957</u> Month <u>Dec</u> Day <u>24</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry C. Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Sallie H. Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or temporary) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Richard Gordon R. H. Crisfield</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - (generalized)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcer</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>Dec 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>57</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u>		ADDRESS (Street, city or town, state) <u>Crisfield, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>		DATE SIGNED <u>Dec 26 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 36 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hannon</u>		24. REGISTRAR'S SIGNATURE <u>Barbara S. Adams</u>	
ADDRESS <u>Crisfield Md.</u>		DATE <u>12/31/57</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John J. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15, 1885</i></p>		<p>4. Place of birth: <i>St. Louis, Mo.</i></p>	
<p>5. Date of death: <i>Dec 10, 1945</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Immediate cause: <i>Myocardial infarction</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Usual place of abode: <i>Home</i></p>	
<p>11. Name of physician: <i>Dr. J. H. Jones</i></p>		<p>12. Name of funeral director: <i>John J. Smith</i></p>	
<p>13. Name of informant: <i>John J. Smith</i></p>		<p>14. Address of informant: <i>1234 Main St.</i></p>	
<p>15. Signature of physician: <i>J. H. Jones</i></p>		<p>16. Signature of informant: <i>John J. Smith</i></p>	

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THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A PERSON AUTHORIZED BY THE BOARD OF HEALTH. IT IS NOT VALID IF SIGNED BY A PERSON WHO IS NOT A PHYSICIAN OR A PERSON AUTHORIZED BY THE BOARD OF HEALTH.

13594

CERTIFICATE OF DEATH

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b since birth			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First INFANT Middle GIRL Last STEVENSON				4. DATE OF DEATH Month December Day 9 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 3 Days 5		IF UNDER 24 HRS. Hours 3 Mins. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Albert Adkins				14. MOTHER'S MAIDEN NAME Zelda Stevenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Zelda Stevenson—139 Tyler St.—Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 9, 1957 , to Dec. 9, 1957 , that I last saw the deceased alive on Dec. 9, 1957 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St.—Crisfield, Md. DATE SIGNED Dec 14, 1957							
ACTUAL SIGNATURE Sarah M. Peyton M.D.				PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton, M. D. Main St.—Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Lawsonia Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE 12/20/57		24b. REGISTRAR'S SIGNATURE Barbara S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BY: John J. ... DATE: ...

BUREAU V. S.

DEC 23 1957

EX-111-32

Dr. Sarah M. Peyton, M. D.

Jameson Company

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Figure 1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13596

13595

CERTIFICATE OF DEATH

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marion Station, Maryland				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THURMAN Middle CHARLES Last TAYLOR, SR.				4. DATE OF DEATH Month December Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) near Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William T. Taylor				14. MOTHER'S MAIDEN NAME Amanda Major			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lottie Taylor--R.F.D. Marion Station, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Condition - Myocarditis & Infarct DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operated on at H. S. P. H. Hosp. Balto, Md for Carcinoma of prostate 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that I attended the deceased from Nov. 10, 1957 to Dec. 28, 1957 , that I last saw the deceased alive on 12-28, 1957 , and that death occurred at 8:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Marion Station - Md. DATE SIGNED 12-30-57 ACTUAL SIGNATURE George C. Coulbourne M.D. PHYSICIAN'S NAME (Type) Dr. George C. Coulbourne, M.D. Marion Station, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Marion Station, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 12-30-57		24b. REGISTRAR'S SIGNATURE Nellie D. Payne	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Dec. 30, 1957

Male

Female

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598

Reg. Dist. No. 260

13596

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monie			c. LENGTH OF STAY IN 1b Life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Monie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ellen Waters				4. DATE OF DEATH Month Day Year December 12, 19 57				
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?		
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ?		17. INFORMANT Address Louis Bounds - Rt.3 - Princess Anne, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Died in her sleep. DUE TO (b) DUE TO (c)</p> </div> <div style="width: 65%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R.H. Johnson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R.H. Johnson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec 27-1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-57		22c. NAME OF CEMETERY OR CREMATORY Grace Cem.		22d. LOCATION (City, town, or county) (State) Venton, Somerset Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William A. James Jr. Princess Anne Md				24a. REC'D BY REGISTRAR DATE 12/28/57		24b. REGISTRAR'S SIGNATURE R.H. Johnson, M.D.		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar for burial, cremation, or removal.

Great Caraway Street Bureau.
Bred in the shop-

R. H. Johnson
R. H. Johnson

DEC 31 1957

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RECEIVED
DEC 31 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13597

CERTIFICATE OF DEATH

Reg. Dist. No.

13599

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u>		c. LENGTH OF STAY IN TB <u>14 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u> X1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #1</u>				d. STREET ADDRESS <u>RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mollie Johnson Waters</u>			4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>19 57</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1888</u>		9. AGE (In years last birthday) <u>69</u> yrs.	10. IF UNDER 1 YEAR Months <u>30</u> Days <u>19</u> Hours <u>57</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Collins</u>				14. MOTHER'S MAIDEN NAME <u>Vina Cluff</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>220-26-3134</u>		17. INFORMANT <u>John Waters Westover, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>October 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>57</u> , and that death occurred at <u>2 a.</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u>				ADDRESS (Street, city or town, state) <u>Market Street</u>		DATE SIGNED <u>12/31/57</u>			
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius Sr.</u>				<u>Pocomoke City, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ M.E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Pocomoke City, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6 1958</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Luella Byrd</u>					

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1955		BALTIMORE, MD		JANE E. RAY		4/4/68		BALTIMORE, MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CONDUCTOR		1955		BALTIMORE, MD		BALTIMORE & ANNE ARBOR RAILROAD		4/4/68		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		SUICIDE		4/4/68		BALTIMORE, MD		4/4/68		BALTIMORE, MD	
PHYSICIAN'S SIGNATURE		DATE		PLACE		NAME		DATE		PLACE	
J. EDWARD BROWN		4/4/68		BALTIMORE, MD		J. EDWARD BROWN		4/4/68		BALTIMORE, MD	
CORONER'S SIGNATURE		DATE		PLACE		NAME		DATE		PLACE	
JOHN J. HARRIS		4/4/68		BALTIMORE, MD		JOHN J. HARRIS		4/4/68		BALTIMORE, MD	
FAMILY PHYSICIAN'S SIGNATURE		DATE		PLACE		NAME		DATE		PLACE	
J. EDWARD BROWN		4/4/68		BALTIMORE, MD		J. EDWARD BROWN		4/4/68		BALTIMORE, MD	
FAMILY PHYSICIAN'S SIGNATURE		DATE		PLACE		NAME		DATE		PLACE	
J. EDWARD BROWN		4/4/68		BALTIMORE, MD		J. EDWARD BROWN		4/4/68		BALTIMORE, MD	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 22b 1-3-58 et

Reg. Dist. No. 260

13598

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN lb Life time	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Williams		4. DATE OF DEATH Month Day Year December 27, 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1921
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Williams	
14. MOTHER'S MAIDEN NAME Hattie Dennis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Hattie Dennis - Princess Anne, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonia DUE TO (b) Sepsis DUE TO (c) Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 28-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/57	22c. NAME OF CEMETERY OR CREMATORY John Wesley Cem	22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William A. James Jr		ADDRESS Princess Anne Md	
24a. REC'D BY REGISTRAR 12/30/57		24b. REGISTRAR'S SIGNATURE R. H. Johnson, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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DEC 31 1957

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13599 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item 14, Film G224, 1/21/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount c. LENGTH OF STAY IN 1b 60 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertie Middle M. Last Windsor		4. DATE OF DEATH Month Dec. Day 29 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ford		14. MOTHER'S MAIDEN NAME Clementine Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Mrs. Cecil Ford Fairmount, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Senility (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 29, 1957 , to Dec. 29, 1957 , that I last saw the deceased alive on Dec. 29, 1957 , and that death occurred at 5:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Lewis		DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		ADDRESS (Street, city or town, state) Princess Anne, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1-2-58	22c. NAME OF CEMETERY OR CREMATORY Fairmount cemetery	22d. LOCATION (City, town, or county) (State) Fairmount, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Wilson		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR JAN 3 1958		24b. REGISTRAR'S SIGNATURE R. J. Johnson	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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Review

...and ...

1953 3 iv:

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

13600

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHANCE		c. LENGTH OF STAY IN 1b 5 MONTH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHANCE x2		d. STREET ADDRESS /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETTA Middle ANN Last WRIGHT				4. DATE OF DEATH Month 12 Day 21 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/57	9. AGE (In years last birthday) yrs. 6	IF UNDER 1 YEAR Months 6 Days 21 Hours 19 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME RUFUS H. WRIGHT				14. MOTHER'S MAIDEN NAME DELORES M. SELBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address DELORES WRIGHT ORIOLE, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronch pneumonia - 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.H. Johnson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.H. Johnson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER Dec 23 - 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/24/57		22c. NAME OF CEMETERY OR CREMATORY ST CHARLES		22d. LOCATION (City, town, or county) _____ (State) _____ CHANCE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones Jr				24a. REC'D BY REGISTRAR DATE 12-23-57		24b. REGISTRAR'S SIGNATURE R.H. Johnson	

MEDICAL CERTIFICATION

2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CITY		STATE	

3 days -
Brockhampton -

BUREAU V. E.

DEC 30 1957

RECEIVED
DEC 30 - 1957

R. H. Johnson
1957

15-5-3-3